



Complete Summary

GUIDELINE TITLE

HIV infection: detection, counseling, and referral. Sexually transmitted diseases treatment guidelines 2006.

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention, Workowski KA, Berman SM. HIV infection: detection, counseling, and referral. Sexually transmitted diseases treatment guidelines 2006. MMWR Morb Mortal Wkly Rep 2006 Aug 4;55(RR-11):10-4. [222 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Centers for Disease Control and Prevention. HIV infection: detection, counseling, and referral. Sexually transmitted diseases treatment guidelines. MMWR Recomm Rep 2002 May 10;51(RR-6):7-11.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [January 19, 2005, Nevirapine \(viramune\)](#): Labeling has been revised to include more information on liver toxicity associated with long term use, including a Medication Guide informing patients about risks when used for the treatment of HIV.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **

SCOPE

METHODOLOGY - including Rating Scheme and Cost Analysis

RECOMMENDATIONS

EVIDENCE SUPPORTING THE RECOMMENDATIONS

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

QUALIFYING STATEMENTS

IMPLEMENTATION OF THE GUIDELINE

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

SCOPE

DISEASE/CONDITION(S)

Human immunodeficiency virus (HIV) infection

GUIDELINE CATEGORY

Counseling
Diagnosis
Evaluation
Management
Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

- To update the Sexually Transmitted Diseases Treatment Guidelines 2002 (*MMWR* 2002;51[No. RR-6])
- To assist physicians and other health-care providers in preventing and treating sexually transmitted diseases (STDs)

TARGET POPULATION

Persons with human immunodeficiency virus (HIV) infection and those at risk for infection, including persons seeking evaluation for sexually transmitted diseases

(STDs), injecting-drug users, pregnant women, and infants and children of HIV-infected women

INTERVENTIONS AND PRACTICES CONSIDERED

1. HIV-1 and HIV-2 testing with pre and posttest counseling
 - Obtaining informed consent
 - Screening test with enzyme immunoassay (EIA) or rapid testing
 - Supplemental tests including Western blot (WB) or immunofluorescence assay (IFA)
2. Nucleic acid testing (HIV plasma ribonucleic acid [RNA]) in those suspected of acute retroviral syndrome
3. Antiretroviral drug therapy
4. Referral to HIV clinical care provider as needed
5. Counseling and education for transmission prevention
6. Behavioral and psychosocial services support or referral
7. Evaluation of HIV-positive patients including medical history; physical examination (including gynecologic examination for women); testing for *Neisseria gonorrhoeae* and *Chlamydia trachomatis*; Papanicolaou (Pap) test and wet mount examination of vaginal secretions for women, complete blood count and chemistry profile; toxoplasma antibody test, test for hepatitis C antibodies and tests for prior or current hepatitis A and hepatitis B infection if cost effective; syphilis serology; a CD4+ T-lymphocyte analysis and determination of HIV plasma viral load; a tuberculin skin test; a urinalysis; and a chest radiograph
8. Hepatitis B, hepatitis A, influenza, and pneumococcal vaccination, where appropriate
9. Treatment of other sexually transmitted diseases, as appropriate
10. Partner notification (patient and provider referral)
11. Voluntary counseling and HIV testing for pregnant women
12. HIV testing in infants and children including laboratory evidence in blood or, particularly for patients aged <18 months, HIV nucleic acid testing
13. Referral of infants and children to pediatric HIV infection specialists

MAJOR OUTCOMES CONSIDERED

- Human immunodeficiency virus (HIV)-associated morbidity and mortality
- Alleviation of signs and symptoms
- Prevention of sequelae
- Prevention of transmission of HIV and other sexually transmitted diseases (STDs)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Beginning in 2004, the Centers for Disease Control and Prevention (CDC) personnel and professionals knowledgeable in the field of sexually transmitted diseases (STDs) systematically reviewed evidence (including published abstracts and peer-reviewed journal articles) concerning each of the major STDs, focusing on information that had become available since publication of the *Sexually Transmitted Diseases Treatment Guidelines, 2002*. Background papers were written and tables of evidence constructed summarizing the type of study (e.g., randomized controlled trial or case series), study population and setting, treatments or other interventions, outcome measures assessed, reported findings, and weaknesses and biases in study design and analysis. A draft document was developed on the basis of the reviews.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus (Consensus Development Conference)

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

In April 2005, the Centers for Disease Control and Prevention (CDC) staff members and invited consultants assembled in Atlanta, Georgia, for a 3-day meeting to present the key questions regarding sexually transmitted disease (STD) treatment that emerged from the evidence-based reviews and the information available to answer those questions. When relevant, the questions focused on four principal outcomes of STD therapy for each individual disease: 1) microbiologic cure, 2) alleviation of signs and symptoms, 3) prevention of sequelae, and 4) prevention of transmission. Cost-effectiveness and other advantages (e.g., single-dose formulations and directly observed therapy of specific regimens) also were discussed. The consultants then assessed whether the questions identified were relevant, ranked them in order of priority, and attempted to arrive at answers using the available evidence. In addition, the

consultants evaluated the quality of evidence supporting the answers on the basis of the number, type, and quality of the studies.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Infection with human immunodeficiency virus (HIV) produces a spectrum of disease that progresses from a clinically latent or asymptomatic state to acquired immunodeficiency syndrome (AIDS) as a late manifestation. The pace of disease progression varies. In untreated patients, the time between infection with HIV and the development of AIDS ranges from a few months to as long as 17 years (median: 10 years). The majority of adults and adolescents infected with HIV remain symptom-free for extended periods, but viral replication is active during all stages of infection and increases substantially as the immune system deteriorates. In the absence of treatment, AIDS will develop eventually in nearly all HIV-infected persons.

Improvements in antiretroviral therapy and increasing awareness among both patients and health-care providers of the risk factors associated with HIV transmission have led to more testing for HIV and earlier diagnosis, frequently before symptoms develop. However, the conditions of nearly 40% of persons who acquire HIV infection continue to be diagnosed late, within 1 year of acquiring AIDS. Prompt diagnosis of HIV infection is essential for multiple reasons. Treatments are available that slow the decline of immune system function; use of these therapies has been associated with substantial declines in HIV-associated morbidity and mortality in recent years. HIV-infected persons who have altered immune function are at increased risk for infections for which preventive measures are available (e.g., *Pneumocystis jiroveci* pneumonia, toxoplasma encephalitis [TE], disseminated *Mycobacterium avium* complex [MAC] disease, tuberculosis [TB], and bacterial pneumonia). Because of its effect on the immune system, HIV affects the diagnosis, evaluation, treatment, and follow-up of multiple other diseases and might affect the efficacy of antimicrobial therapy for some STDs. Finally, the early diagnosis of HIV enables health-care providers to

counsel infected patients, refer them to various support services, and help prevent HIV transmission to others. Acutely infected persons might have elevated HIV viral loads and, therefore, might be more likely to transmit HIV to their partners.

Proper management of HIV infection involves a complex array of behavioral, psychosocial, and medical services. Services might not be available in STD-treatment facilities. Therefore, referral to a health-care provider or facility experienced in caring for HIV-infected patients is advised. Providers working in STD-treatment facilities should be knowledgeable about the options for referral available in their communities. While receiving care in STD-treatment facilities, HIV-infected patients should be educated about HIV infection and the various options for available support services and HIV care.

A detailed discussion of the multiple, complex services required for management of HIV infection is beyond the scope of this section; however, this information is available in other published resources. In subsequent sections, this report provides information regarding diagnostic testing for HIV infection, counseling patients who have HIV infection, referral of patients for support services, including medical care, and the management of sex and injecting-drug partners in STD-treatment facilities. In addition, the report discusses HIV infection during pregnancy and in infants and children.

Detection of HIV Infection: Screening and Diagnostic Testing

All persons who seek evaluation and treatment for STDs should be screened for HIV infection. Screening should be routine, regardless of whether the patient is known or suspected to have specific behavioral risks for HIV infection.

Consent and Pretest Information

HIV screening should be voluntary and conducted only with the patient's knowledge and understanding that testing is planned. Persons should be informed orally or in writing that HIV testing will be performed unless they decline (i.e., opt-out screening). Oral or written communications should include an explanation of positive and negative test results, and patients should be offered an opportunity to ask questions and to decline testing.

Prevention Counseling

Prevention counseling does not need to be explicitly linked to the HIV-testing process. However, some patients might be more likely to think about HIV and consider their risks when undergoing an HIV test. HIV testing might present an ideal opportunity to provide or arrange for prevention counseling to assist with behavior changes that can reduce risk for acquiring HIV infection. Prevention counseling should be offered and encouraged in all health-care facilities serving patients at high risk and in those (e.g., STD clinics) where information on HIV-risk behaviors is routinely elicited.

Diagnostic Testing

HIV infection usually is diagnosed by tests for antibodies against HIV-1. Some combination tests also detect antibodies against HIV-2 (i.e., HIV-1/2). Antibody testing begins with a sensitive screening test (e.g., the enzyme immunoassay [EIA] or rapid test). The advent of HIV rapid testing has enabled clinicians to make a substantially accurate presumptive diagnosis of HIV-1 infection within half an hour. This testing can facilitate the identification of the more than 250,000 persons living with undiagnosed HIV in the United States. Reactive screening tests must be confirmed by supplemental test (e.g., the Western blot [WB]) or an immunofluorescence assay (IFA). If confirmed by a supplemental test, a positive antibody test result indicates that a person is infected with HIV and is capable of transmitting the virus to others. HIV antibody is detectable in at least 95% of patients within 3 months after infection. Although a negative antibody test result usually indicates that a person is not infected, antibody tests cannot exclude recent infection.

The majority of HIV infections in the United States are caused by HIV-1. However, HIV-2 infection should be suspected in persons who have epidemiologic risk factors, including being from West Africa (where HIV-2 is endemic) or having sex partners from endemic areas, having sex partners known to be infected with HIV-2, or having received a blood transfusion or a nonsterile injection in a West African country. HIV-2 testing also is indicated when clinical evidence of HIV exists but tests for antibodies to HIV-1 viral load are not positive, or when HIV-1 WB results include the unusual indeterminate pattern of *gag* (p55, p24, p17) plus *pol* (p66, p51, p31) bands in the absence of *env* (gp160, gp120, gp42) bands.

Health-care providers should be knowledgeable about the symptoms and signs of acute retroviral syndrome, which is characterized by fever, malaise, lymphadenopathy, and skin rash. This syndrome frequently occurs in the first few weeks after HIV infection, before antibody test results become positive. Suspicion of acute retroviral syndrome should prompt nucleic acid testing (HIV plasma ribonucleic acid [RNA]) to detect the presence of HIV, although not all nucleic acid tests are approved for diagnostic purposes; a positive HIV nucleic acid test should be confirmed by subsequent antibody testing to document seroconversion (using standard methods, EIA, and WB). Acutely infected patients might be highly contagious because of increased plasma and genital HIV RNA concentrations and might be continuing to engage in risky behaviors. Current guidelines suggest that persons with recently acquired HIV infection might benefit from antiretroviral drugs, and such patients may be candidates for clinical trials. Therefore, patients with acute HIV infection should be referred immediately to an HIV clinical care provider.

Diagnosis of HIV infection should prompt efforts to reduce the risk behavior that resulted in HIV infection and could result in transmission of HIV to others. Early counseling and education are particularly important for persons with recently acquired infection, because HIV plasma RNA levels are characteristically high during this phase of infection and probably constitute an increased risk for HIV transmission. The following are specific recommendations for diagnostic testing for HIV infection.

- HIV screening is recommended for all persons who seek evaluation and treatment for STDs.
- HIV testing must be voluntary.

- Consent for HIV testing should be incorporated into the general consent for care (verbally or in writing) with an opportunity to decline (opt-out screening).
- HIV rapid testing must be considered, especially in clinics where a high proportion of patients do not return for HIV test results.
- Positive screening tests for HIV antibody must be confirmed by a supplemental test (either WB or IFA) before being considered diagnostic of HIV infection.
- Persons who have positive HIV test results (screening and confirmatory) must receive initial HIV prevention counseling before leaving the testing site. Such persons should 1) receive a medical evaluation and, if indicated, behavioral and psychological services, or 2) be referred for these services.
- Providers should be alert to the possibility of acute retroviral syndrome and should perform nucleic acid testing for HIV, if indicated. Patients suspected of having recently acquired HIV infection should be referred for immediate consultation with a specialist.

Counseling for Patients with HIV Infection and Referral to Support Services

Persons can be expected to be distressed when first informed of a positive HIV test result. Such persons face multiple major adaptive challenges, including 1) accepting the possibility of a shortened life span, 2) coping with the reactions of others to a stigmatizing illness, 3) developing and adopting strategies for maintaining physical and emotional health, and 4) initiating changes in behavior to prevent HIV transmission to others. Many persons will require assistance with making reproductive choices, gaining access to health services, confronting possible employment or housing discrimination, and coping with changes in personal relationships. Therefore, behavioral and psychosocial services are an integral part of health care for HIV-infected persons. Such services should be available on site or through referral when HIV infection is diagnosed. A comprehensive discussion of specific recommendations is available in the [Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-care Settings](#). Innovative and successful interventions to decrease risk taking by HIV-infected patients have been developed for diverse populations.

Practice settings for offering HIV care differ depending on local resources and needs. Primary-care providers and outpatient facilities should ensure that appropriate resources are available for each patient to avoid fragmentation of care. Although a single source that is capable of providing comprehensive care for all stages of HIV infection is preferred, the limited availability of such resources frequently results in the need to coordinate care among medical and social service providers in different locations. Providers should avoid long delays between diagnosis of HIV infection and access to additional medical and psychosocial services. The use of HIV rapid testing can help avoid unnecessary delays.

Recently identified HIV infection might not have been recently acquired. Persons newly diagnosed with HIV might be at any stage of infection. Therefore, health-care providers should be alert for symptoms or signs that suggest advanced HIV infection (e.g., fever, weight loss, diarrhea, cough, shortness of breath, and oral candidiasis). The presence of any of these symptoms should prompt urgent

referral for specialty medical care. Similarly, providers should be alert for signs of psychologic distress and be prepared to refer patients accordingly.

Diagnosis of HIV infection reinforces the need to counsel patients regarding high-risk behaviors, because the consequences of such behaviors include the risk for acquiring additional STDs and for transmitting HIV (and other STDs) to other persons. Such attention to behaviors in HIV-infected persons is consistent with national strategies for HIV prevention. Providers should refer patients for prevention counseling and risk-reduction support concerning high-risk behaviors (e.g., substance abuse and high-risk sexual behavior). In multiple recent studies, researchers have developed successful prevention interventions for different HIV-infected populations that can be adapted to individuals.

Persons with newly diagnosed HIV infection who receive care in the STD treatment setting should be educated concerning what to expect as they enter medical care for HIV infection. In nonemergent situations, the initial evaluation of HIV-positive patients usually includes the following:

- a detailed medical history, including sexual and substance-abuse history, vaccination history, previous STDs, and specific HIV-related symptoms or diagnoses
- a physical examination, including a gynecologic examination for women
- testing for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* (and for women, a Papanicolaou [Pap] test and wet mount examination of vaginal secretions)
- complete blood and platelet counts and blood chemistry profile
- toxoplasma antibody test
- tests for antibodies to hepatitis C virus (HCV); testing for previous or present hepatitis A virus (HAV) or hepatitis B virus (HBV) infection is recommended if determined to be cost-effective before considering vaccination (see the National Guidelines Clearinghouse [NGC] summaries of the Centers for Disease Control and Prevention [CDC] guidelines Hepatitis A and Hepatitis B)
- syphilis serology
- a CD4+ T-lymphocyte analysis and determination of HIV plasma viral load
- a tuberculin skin test (sometimes referred to as a purified protein derivative)
- a urinalysis
- a chest radiograph

Some specialists recommend type-specific testing for herpes simplex virus type 2 (HSV-2) if herpes infection status is unknown. A first dose of hepatitis A and/or hepatitis B vaccination for previously unvaccinated persons for whom vaccine is recommended (see the NGC summaries of the CDC guidelines [Prevention of Hepatitis A Through Active or Passive Immunization](#) and [Comprehensive Immunization Strategy to Eliminate Transmission of Hepatitis B Virus Infection in the United States](#)) should be administered at this first visit.

In subsequent visits, when the results of laboratory and skin tests are available, antiretroviral therapy may be offered, if indicated, after initial antiretroviral resistance testing is performed and specific prophylactic medications are administered to reduce the incidence of opportunistic infections (e.g., *Pneumocystis jiroveci* pneumonia, toxoplasmic encephalitis [TE], disseminated *Mycobacterium avium* complex [MAC] infection, and tuberculosis [TB]). The

vaccination series for hepatitis A and/or hepatitis B should be offered for those in whom vaccination is recommended. Influenza vaccination should be offered annually, and pneumococcal vaccination should be given if it has not been administered in the previous 5 years.

Providers should be alert to the possibility of new or recurrent STDs and should treat such conditions aggressively. The occurrence of an STD in an HIV-infected person is an indication of high-risk behavior and should prompt referral for counseling. Because many STDs are asymptomatic, routine screening for curable STDs (e.g., syphilis, gonorrhea, and chlamydia) should be performed at least yearly for sexually active persons. Women should be screened for cervical cancer precursor lesions by annual Pap smears. More frequent STD screening might be appropriate depending on individual risk behaviors, the local epidemiology of STDs, and whether incident STDs are detected by screening or by the presence of symptoms.

Newly diagnosed HIV-infected persons should receive or be referred for a thorough psychosocial evaluation, including ascertainment of behavioral factors indicating risk for transmitting HIV. Patients might require referral for specific behavioral intervention (e.g., a substance abuse program), mental health disorders (e.g., depression), or emotional distress. They might require assistance with securing and maintaining employment and housing. Women should be counseled or appropriately referred regarding reproductive choices and contraceptive options. Patients with multiple psychosocial problems may be candidates for comprehensive risk-reduction counseling and services.

The following are specific recommendations for counseling and referral:

- Persons who test positive for HIV antibody should be counseled, either on site or through referral, concerning the behavioral, psychosocial, and medical implications of HIV infection.
- Health-care providers should be alert for medical or psychosocial conditions that require immediate attention.
- Providers should assess newly diagnosed patients' need for immediate medical care or support needs and link them to services in which health-care personnel are experienced in providing care for HIV-infected persons. Such persons might need medical care or services for substance abuse, mental health disorders, emotional distress, reproductive counseling, risk-reduction counseling, and case management. Providers should follow-up to ensure that patients have received the needed services.
- Patients should be educated regarding what to expect in follow-up medical care.

Several innovative interventions for HIV prevention have been developed for diverse at-risk populations, and these can be locally replicated or adapted. Involvement of nongovernment organizations and community-based organizations might complement such efforts in the clinical setting.

Management of Sex Partners and Injecting-Drug Partners

Clinicians evaluating HIV-infected persons should collect information to determine whether any partners should be notified concerning possible exposure to HIV.

When referring to persons who are infected with HIV, the term "partner" includes not only sex partners but also injecting-drug users (IDUs) who share syringes or other injection equipment. The rationale for partner notification is that the early diagnosis and treatment of HIV infection in these partners might reduce morbidity and provides the opportunity to encourage risk-reducing behaviors. Partner notification for HIV infection must be confidential and depends on the voluntary cooperation of the patient. Specific guidance regarding spousal notification may vary by jurisdiction.

Two complementary notification processes, patient referral and provider referral, can be used to identify partners. With patient referral, patients directly inform their partners of their exposure to HIV infection. With provider referral, trained health department personnel locate partners on the basis of the names, descriptions, and addresses provided by the patient. During the notification process, the confidentiality of patients is protected; their names are not revealed to partners who are notified. Many state health departments provide these services.

The following are specific recommendations for implementing partner-notification procedures:

- HIV-infected patients should be encouraged to notify their partners and to refer them for counseling and testing. If requested by the patient, health-care providers should assist in this process, either directly or by referral to health department partner-notification programs.
- If patients are unwilling to notify their partners or if they cannot ensure that their partners will seek counseling, physicians or health department personnel should use confidential partner notification procedures.
- Partners who are contacted within 72 hours of a high-risk sexual or injecting-drug exposure to an HIV-infected partner, which involves exposure to genital secretions and/or blood, should be offered postexposure prophylaxis (PEP) with combination antiretroviral therapy to complete a 28-day course.

Special Considerations

Pregnancy

All pregnant women in the United States should be tested for HIV infection as early during pregnancy as possible. Testing should occur after the patient is notified that she will be tested for HIV as part of the routine panel of prenatal tests, unless she declines (i.e., opt-out screening). For women who decline, providers should continue to strongly encourage testing and address concerns that pose obstacles to testing. Women who decline testing because they have had a previous negative HIV test should be informed of the importance of retesting during each pregnancy. Testing pregnant women is particularly important, not only to maintain the health of the patient, but also because interventions (i.e., antiretroviral and obstetrical) can reduce the risk of perinatal transmission of HIV.

After pregnant women have been identified as being HIV-infected, they should be educated about the risk of perinatal infection. Evidence indicates that, in the absence of antiretroviral and other interventions, 15%-25% of infants born to HIV-infected mothers will become infected with HIV; such evidence also indicates

that an additional 12%-14% will become infected during breastfeeding where HIV-infected women breastfeed their infants into the second year of life.

The risk of perinatal HIV transmission can be reduced substantially to <2% through the use of antiretroviral regimens and obstetrical interventions (i.e., zidovudine [AZT] or nevirapine and elective cesarean-section at 38 weeks of pregnancy) and by avoiding breastfeeding. Pregnant women who are HIV-infected should be counseled concerning their options (either on-site or by referral), given appropriate antenatal treatment, and advised not to breastfeed their infants (for women living in the United States, where infant formula is readily available and can be safely prepared).

HIV Infection Among Infants and Children

Diagnosis of HIV infection in a pregnant woman indicates the need to consider whether other children of the woman might be infected. Infants and young children with HIV infection differ from adults and adolescents with respect to the diagnosis, clinical presentation, and management of HIV disease. For example, because maternal HIV antibody passes through the placenta, antibody tests for HIV are expected to be positive in the sera of both infected and uninfected infants born to seropositive mothers. A definitive determination of HIV infection for an infant aged <18 months is usually based on HIV nucleic acid testing. Management of infants, children, and adolescents who are known or suspected to be infected with HIV requires referral to physicians familiar with the manifestations and treatment of pediatric HIV infection.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

Throughout the 2006 guideline document, the evidence used as the basis for specific recommendations is discussed briefly. More comprehensive, annotated discussions of such evidence will appear in background papers that will be published in a supplement issue of the journal *Clinical Infectious Diseases*.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Earlier initiation of treatments that slow the decline of immune system function
- Use of therapies associated with substantial declines in HIV-associated morbidity and mortality

- Improved diagnosis, evaluation, treatment, and follow-up of concurrent diseases
- Improvement in the efficacy of antimicrobial therapy for some sexually transmitted diseases (STDs)
- Improvement in health-care providers' ability to counsel HIV-infected patients, refer them to various support services, and help prevent HIV transmission to others

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These recommendations were developed in consultation with public- and private-sector professionals knowledgeable in the treatment of patients with sexually transmitted diseases (STDs). The recommendations are applicable to various patient-care settings, including family planning clinics, private physicians' offices, managed care organizations, and other primary-care facilities.
- These recommendations are meant to serve as a source of clinical guidance: health-care providers should always consider the individual clinical circumstances of each person in the context of local disease prevalence. These guidelines focus on the treatment and counseling of individual persons and do not address other community services and interventions that are important in STD/human immunodeficiency virus (HIV) prevention.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention, Workowski KA, Berman SM. HIV infection: detection, counseling, and referral. Sexually transmitted diseases treatment guidelines 2006. MMWR Morb Mortal Wkly Rep 2006 Aug 4;55(RR-11):10-4. [222 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1993 (revised 2006 Aug 4)

GUIDELINE DEVELOPER(S)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

GUIDELINE DEVELOPER COMMENT

These guidelines for the treatment of persons who have sexually transmitted diseases (STDs) were developed by CDC after consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta, Georgia, during April 19–21, 2005.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Centers for Disease Control and Prevention. HIV infection: detection, counseling, and referral. Sexually transmitted diseases treatment guidelines. MMWR Recomm Rep 2002 May 10;51(RR-6):7-11.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site:

- [HTML Format](#)
- [Portable Document Format \(PDF\)](#)

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Workowski KA, Levine WC, Wasserheit JN. U.S. Centers for Disease Control and Prevention guidelines for the treatment of sexually transmitted diseases: an opportunity to unify clinical and public health practice. Ann Intern Med. 2002 Aug 20;137(4):255-62. Electronic copies: Available through [Annals of Internal Medicine Online](#).
- The CDC Sexually Transmitted Diseases Treatment Guidelines 2004 for PDA or Palm OS. Available from the [CDC National Prevention Information Network \(NPIN\) Web site](#).

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on August 19, 2002. This NGC summary was updated on January 21, 2005, following the release of a public health advisory from the U.S. Food and Drug Administration regarding the use of nevirapine. This NGC summary was updated by ECRI on October 6, 2006.

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